Patient education and health promotion: clinical health promotion — the conceptual link

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Abstract

A model linking health promotion, health education and patient education is presented. Claims to health education being distinguishable from patient education on the basis of setting and working with well, as opposed to sick, individuals are disputed. Many health education encounters create the role of prom-patient for the individual receiving care. A further distinction is made between patient education and clinical health promotion on the basis of the focus of care as seen by the professional. The linking elements in the model are those of the patient role and relationships adopted, another distinction is seen in the area of the focus of the encounter. Traditional patient education focuses on the disease process whereas clinical health promotion emphasises the place of illness in the person’s life and looks to influence non-medical factors that impinge on the disease. ©1998 Elsevier Science Ireland Ltd.

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1. Introduction

Patient education is often viewed as the poor cousin of health promotion. It suffers from being viewed as a less skilled form of health promotion. There are assumptions that patient education is distinguishable from health promotion but the basis of these distinctions is not always made clear. One popular distinction is summed up by the statement that patient education “is condition specific” [1]. This offers no clarification or analysis of the relationship between the two. Others base the difference on the location of the activity or the status of the individual receiving care. Many of the reviews of health promotion seek means of analysis which exclude patient education as a legitimate form of health promotion. This is often on the basis that health promotion is to do with the promotion of health and well individuals whereas patient education is about sickness and the treatment of unwell individuals. As Hellstrom notes “policy makers and people in general are prone to hold that
health promotion, too, exclusively deals with the prevention of illness and diseases within a population” ([2], p. 248). Such a view seeks to locate patient education outside the remit of health promotion. This article by using the term clinical health promotion shows how these objections can be overcome by making a link to the principles contained in the Ottawa Charter and outlining how it can contribute to the promotion of health [3].

A recent edition of Patient Education and Counselling introduced the term clinical health promotion [4]. This was related to health promotion with patients carried on in a clinical setting and incorporated both “health education and patient counselling aimed at behaviour change in patients at risk for lifestyle related illnesses” [4]. In the same edition of the journal the term was used in different articles to mean different things, some equating it with old style patient education others with health education in a primary care setting [5,6]. A clearer distinction came in the editorial of the same issue where Herbert, Visser and Green [7] noted that “clinical health promotion, we believe, predisposes, enables and reinforces patients to take greater control of the non-medical determinants of their own health” (p. 224). Using this notion of non-medical determinants a distinction is made between patient education and clinical health promotion. This focus proposed by Herbert Visser and Green locates disease within a larger framework whereas patient education focuses on disease as the prime object. An attempt is made to apply the principles of the Ottawa Charter to the area of patient education, so that the focus is not the disease itself but disease within the larger remit of life. The Ottawa Charter when talking of health notes that “[h]ealth is therefore seen as a resource for everyday life and not the objective of living” [3]. In a similar way disease is not the primary focus of clinical health promotion but merely another component (maybe one to be overcome) in helping people to cope with everyday life.

Tones and Tilford [1] distinguish between the various elements by means of categorisation and definition. They note that patient education is “condition-specific education with patients. Frequently focused on tertiary levels of prevention but includes activities directed to primary and secondary prevention” (p. 150). It is also significant that the first part of the above quote is frequently acknowledged but the second is ignored or passed over. Tones and Tilford do not go on to say how patient education can also include activities at primary and secondary level. Many critiques of health promotion relate to the fact that it is focused on specific diseases and concerned with prevention of disease rather than the promotion of health, so even health promotion is subject to the same critique of being illness and disease focused [8,9].

This article sets out the development of health promotion and analyses the relationship between patient education and health promotion by examining the intermediate process of health education. In attempting this, the case is put forward that much of the work primary care staff call health education, whether carried out by doctors or nurses, does not differ in its application from that of hospital based staff. Both it is argued are concerned with a focus on secondary care, the patient role and a model of health which is based on a medical or disease prevention approach to health promotion. From this base distinctions are made between the new term clinical health promotion and patient education. The intent of the article is to draw in those professionals in secondary and tertiary care areas who feel that health promotion is the preserve of community-based and specialist health promoters but also to help expand the scope of all patient education in broadening the focus of the intervention. In doing this it becomes clear that many activities called health education are in fact closer to patient education.

2. Health promotion as an umbrella term

Dines and Cribb [10] describe health promotion as a concept that “encompasses health education and all the other routes to health” (p. 28). They describe this in colloquial terms as health promotion being “health education plus ”.
This assumes that health education is part of health promotion. What the relationship consists of, is not clear and it does not make clear what health promotion or health education itself is. This approach to health promotion as an overarching umbrella term including within its remit all lesser concepts, is one that is commonly used. It means that health promotion is defined by the sum of its parts rather than having to be defined in its own right.

There is a tendency to reduce health promotion activities to the skills required to carry out the activity [11]. This does not take account of roles or relationships. The current emphasis in primary care is on the implementation of screening programmes, the focus of which is the early detection of disease processes and their treatment [12]. This tension is reflected by calls for patient education to focus on the chronic sick as opposed to the worried well. Eijk [6] for example calls for a focusing of health promotion on patients with a chronic disease. Le Touze and Calnan report on the tendency of general practitioners to focus their efforts on risk factor identification and screening [13]. Herbert [4] contends that health promotion activities only form a small part of physicians work in North America and that attempts are currently under way to increase it. From Canada Collins (14) reports on the concern with shifting existing health care emphasis from disease process to the role of social determinants of health. This article takes up this latter theme and suggests that social determinants are not just a concern at a macro-level of operation but also should be a concern of micro-level process such as health education or patient education.

It seems churlish to suggest that, while disease and illness exist, approaches based on dealing with ill health and illness are not valuable and necessary endeavours or indeed that patients do not welcome such approaches. The argument here is their place within the rubric of health promotion and what constitutes the various elements. Efforts to prevent disease and further suffering deserve a place within the rubric of health promotion, as the prevention and alleviation of disease contribute to health. The area of primary care will be examined as Herbert et al. [7] suggest that this is the area through family physicians that offers most hope of implementing their view of clinical health promotion.

3. Health education in primary care settings

At first glance many community and primary care activities fit easily under the health promotion label. They involve well people and occur outside an institutional setting. Such a view neglects the impact of the patient role and model of operation used.

Many of the activities in community settings are based on the notion of detecting and treating disease and as such are an extension of hospital activities to community settings [15,16]. The intrusion of screening into all areas of life has the potential to turn well individuals into patients or the term preferred here proto-patients. This is similar to arguments in sociology over the sick role, in order to occupy the sick role you do not have to be sick, similarly with the patient role you do not necessarily have to have an illness or disease. The attitudes of professionals and the context of care may encourage or even force individuals into the patient role. The patient role is not an objective reality but rather a social one determined by social and contextual situations. Lupton [12] argues that the medical model is all invasive and that the intrusion of the model into all areas of life results in areas and conditions not previously under the gaze of medicine being medicalised.

Dines [17], in her analysis of health education and nurses in primary care, suggests that nurses may not be assuming individuals have full control over their health status, if it is accepted that to speak of health education at all is to be referring to that part of the determinants of health over which the individual has some control. (p. 221).

This appears to rule out any radical form of health education concerning the determinants of
health. The danger with this approach is that nurses, in common with other professionals, reduce presenting conditions to nursing agendas because the nurse rather than the client has no control over social issues [18]. So the nurse decides what areas the client has control over and only deals with these or turns them into concerns that may be dealt with. Dines [17] gives the example of poverty and suggests that nurses do not tackle poverty as it is outside the influence of the nurse. Another way of viewing this is that nurses do tackle poverty, teaching individuals or families to cope within the limits of their poverty. Again it may be that poverty is reinterpreted as lifestyle and behavioural issues. This deals with the issue from an individualistic perspective and does not help people understand the cause of their ill health. A radical approach to health education would incorporate both elements [19]. This may help individuals understand why there are limits to their choice rather than encouraging them to cope within the limits of their choice. Waitzkin argues that this is because social factors cannot be controlled by the professional and threaten the power relationships in the encounter. Social factors are reinterpreted into the hegemony of the encounter which is a medical and disease driven ideology. According to Waitzkin [18] social factors presented by clients or patients in medical encounters are not explored in any great depth. They are absorbed within the dominant discourse and reinterpreted in this light. Non-medical determinants of health as represented by poverty and social class are reinterpreted within medical and health care encounters as factors such as lifestyle or behaviour. where they can viewed as risk factors rather than indicative of risk. Stacey says the indicators of risk end up being considered the risk and can be used as labelling or stigmatising devices rather than as analytic categories [20]. This is largely due to the inability of health care providers to have any influence on social and cultural matters. So structural issues such as poverty become issues of lifestyle or behaviour which are seen as amenable to change. Waitzkin [18] and Lupton [12] argue that such behaviours are due to the structuralist position doctors and other health care providers adopt in their attempt to maintain a social distance from patients in order to be seen as experts. Equipping professionals with skills may further increase this gap and disadvantage patients.

The notion that health education and patient education are different is not disputed here: what is being argued is that many of the activities termed health education in the community setting are more aptly termed patient education. This is because they focus on disease patterns and individual causality and seek explanation in the realm of the medical and scientific rather than the social.

The idea that patient education is authoritative is a stereotype, and while it may be the dominant approach to patient education, it is not the only one. The notion that all community health education practice is facilitative and based on clients’ needs is also a stereotype. As Labonte [21] notes

**Whether health care was based in doctors offices, hospitals or public health units, the emphasis remained on treating or preventing disease by correcting problems in the mechanical functions of the body. (p. 4).**

The concepts underlying health education practice and more recently health promotion have been as much influenced by medical notions of health as any broader socioenvironmental approach. The major approach to health determinants has been based on the medical model which is concerned with the absence of disease or infirmity and the health determinant becomes that which causes disease. Such an approach to health education is probably not surprising within a hospital setting given the dominance of the medical model and the presentation of disease and illness. The fact that much health promotion and education in the community has been based on a similar model of operation has been overlooked. This is in opposition to the view of the WHO that health promotion should focus on identifying and enabling individuals to control the determinants that influence health [3]. The
contention is that such an approach is based more on attitudes and perceptions than skills.

4. The influence of the Ottawa charter definition

The definition of health promotion by the World Health Organisation [3] in the Ottawa Charter as "the process of enabling people to increase control over and to improve their health" still seems to locate health at an individual level. Structural changes are seen to be necessary in order to help individuals make healthy choices rather than any direct impact they may have on health. The danger with the above definition and model of operation is that because of its lack of making explicit its operationalising principles it is subject to interpretation. As Collins [14] points out in the move from health care to health promotion “the absence of an explicit conceptual model of health has the potential to focus only on parts of the problem” (p. 317). This is what has happened with patient education. The part focused on has been the disease process with the absence of a focus on social factors or social factors being regarded as mere fodder for the clinical encounter. Health promotion concentrates on the individual as the prime focus for its attentions: in England this tendency has been reinforced by the Health of the Nation which emphasises individual lifestyle and behaviour ignoring issues such as deprivation and inequity [22-25]. The focus on individuals is not a problem in itself. The reality is that most health care professionals work with and will continue to work with individuals. The problem occurs when this becomes individualistic to the exclusion of social factors and the dominance of the disease model. This reduction of the encounter to this micro political level as Lupton [12] notes allows doctors and patients to ignore “the social and political context in which such encounters take place” (p. 107). The principle enshrined in the Ottawa Charter of looking beyond disease to “the total needs of the individual as a whole person”, require that patient education which focuses on illness reorient itself to a broader focus possibly that offered by clinical health promotion.

5. Patient roles and expectations

The vulnerable state of the patient and the role of the patient are two distinguishing features that set patient education apart. Another distinguishing feature is the location of the activity. These on their own are insufficient to afford a distinguishing analysis of the situation. Many documents see primary care as the appropriate setting for health education and health promotion [26,27]. Indeed the shift of health care resources would seem to help this process.

5.1. Settings and roles

Tones and Tilford [1] contend that patient education may occur in primary, secondary or tertiary care settings so the setting itself may not be an indication of whether it is patient or health education. The key feature may be whether the individual is viewed as a patient or client and this is heavily dependent on the reason for the consultation, whether it is illness, screening or for the promotion of health. It has already been argued that most consultations are not for the purpose of promoting health but are concerned with treating existing illness or detecting early signs of future illness. In terms of health education practice it results in a form of health education which is based on an authoritative and domineering approach. This may be more appropriately termed patient education as the focus is on disease detection and the unwell. It is characterised by the patient role and by being professionally led regardless of the setting in which it occurs.

The other distinguishing feature between health education and patient education is said to be the difference in control exercised by patients or clients. More control is believed exercised by the individual in the health education scenario. This leads to the belief that patient education
offers little opportunity to the patient to negotiate the agenda or to exercise control and indeed in many ways the agenda is set or framed by the presenting condition. This does not mean that negotiation cannot take place on how the patient and his/her family want to take it forward [28]. The patient role is disempowering and this is partly due to the institutional issues and also because the patient in some instances desires it to so [29,30]. As Parsons [31] notes of the patient role “there might be, more generally than had been believed an element of ‘motivatedness’ not only in the etiology of the pathological condition but also in the maintenance of it” (p. 18). This leads on to examining this single view of patient education as being concerned with one approach.

5.2. Patient education as communication skills?

Rather than the wide divide between health promotion in hospitals and community we now begin to see similarities and overlaps. Also rather than as Delaney suggests health promotion clinics being based on a model of health education, it may be more appropriate to suggest that most of the practice is based on a model of patient education [32]. This is because the emphasis is on disease the role of the professional in imparting knowledge for the management of the disease process and the patient role.

Gott and O’Brien [11] noted the overemphasis in nursing and health promotion on the acquisition of skills and the imparting of facts and information. Many of the studies of patient education in hospitals focus on the issue of communications and the imparting of skills. typical of this are the definitions offered by Luker and Caress [33] who define patient education as

the imparting of information, skills or knowledge by the nurse with the aim of bringing about demonstrable behavioural or attitudinal changes in patients.

The problem with this definition is that it limits by its specificity that which constitutes patient education. It also runs the risk of being criticised for being focused on the needs of the nurse and the professional agenda and thus contributing to the stereotype of patient education as being authoritative. This is similar to the criticisms of health education in the late 1970s and early 1980s which led to the demise of health education as a separate discipline and its replacement with health promotion as the dominant paradigm [9]. As Gott and O’Brien [11] note:

“Making people more effective communicators is a dangerous and maybe dishonest business. It promotes token participation and partnership in work with clients ” (p. 141).

Beattie [34] puts forward a similar argument with relation to counselling when he points out counselling can still be accused of victim blaming if it ignores issues of social influences on health as he says.

. . . . . . . it may be more disposed than are persuasion methods to grant the client an active role. its emphasis is clearly almost exclusively on helping individuals to cope (rather than to change their circumstances). and it therefore does not escape the charge of “victim blaming” even if it is a more benign version (p. 175).

Accusations of counselling offering middle class solutions and perspectives to problems are common. As Beattie notes counselling does little to help people change circumstances merely to cope within the limits imposed by them.

5.3. Patient education as a process

The notion that patient education is only about the imparting of information or skills is limiting. It also suggests that there is only one typology or form of patient education. This is in contrast to others who suggest that there are a number of types [1,35,36]. Both Caraher and Tones and Tilford use the typology devised by Roter [36]. In this typology, three approaches to patient education are offered or suggested: authoritative guidance, active participation and independent
decision making. Carahe r [35] describes how these three typologies exist in relation to one another and how, in a patient/nurse encounter, the three can exist and build on one another together adding up to a health promoting encounter. Labonte [21] describes this process of empowerment as transformative and argues that professionals have to want to hand over power and that it not just in the hands of the patient as consumer models of health care would maintain. The main point to note is that patient education can be conceived of as not just one activity or approach but as a number of different approaches either in isolation or combination. One of the problems seems to be that patient education is judged from the perspective of the dominant paradigm of primary care and community practice and how health education is conceived within this area of practice.

The issue of roles is important as individuals at this stage also occupy the role of patient. As defined by Parsons [37], the sick role disempowers individuals but also gives them rights and freedom from certain responsibilities. Many patients welcome this role and occupy it looking to the nurses and other professionals to care for them. Community nurses, on the other hand, deal with those who are not institutionally bound and who are at a different stage on the health continuum. This also has a bearing on the power relationships between the individual and the nurse: it switches from an passive-active role in the patient encounter to mutual-dependence in the client encounter [38]. What is required is the introduction of the mutual dependency relationship into patient education.

Delaney [32] points out that “
health promotion is seen as a combination of activities but practice of any single one (especially health education) is denied the label.” Similarly, many models of health education or health promotion seem to set out to exclude patient education from their remit.

An important issue to address is that patients do not always remain dependent on the nurse and the institution. One of the rights of the sick role as personified by the patient role is not to have to accept responsibility for the illness. A problem arises if this is carried on into the recovery stage where the patient does not accept the responsibility for his or her recovery, choosing instead to locate this responsibility in the nurse. This is why patient education is a process requiring a period during which power is handed back to the patient. This process of empowerment is to a large extent controlled by the nurse. Empowerment is as much a process as an outcome [21]. It is not just something that happens but a process that is facilitated.

6. Role adoption

The fact that people come to hospitals seeking technical help and advice and in a vulnerable state makes it important to recognise the role of patient and all that this implies both for the nurse and patient. The classic sick role allows patients to adopt a role, but it also allows the health care provider to adopt the role of expert. The form of patient education may at this stage therefore be “medico-centered” or based on expert input [1,39]. The fact that this is the dominant paradigm of thought and belief in relation to health and illness makes it appropriate to use as a starting point. The issue of free choice is constrained by peoples’ social and economic circumstances [18,23]. Free choice is constrained when people are sick regardless of their social circumstances, although it may be compounded by the presence of illness. The knowledge and skills that nurses require are not the same as patients require for self care. So part of the process of empowerment is in working with the patient to determine what knowledge and skills they require. This may mark the shift from patient education to clinical health promotion and has implications for the relationship between the health care provider and patient.

7. Relationships

Health care is primarily about relationships and moving from health promotion through
health education to patient education means a change in the relationship from distance to one of intimacy. As was noted earlier, the relationship needs to incorporate elements of mutual dependency. This is due to the fact that the patient role usually involves some element of physical care and this is part of the role of a carer the corresponding to the patient role and it has its own duties and obligations

Health education is that which occurs when individuals are not patients, this is not the same necessarily as well individuals. we have seen that we!! people can occupy the social role of patient while being we!! The focus is on the promotion of health rather than the treatment of illness and the relationship is more intimate than that of the health promotion scenario, but not as formal as in the patient education scenario. Many activities carried out in primary care turn individuals into patients. Screening for high blood pressure is aimed at detecting individuals at risk, once high blood pressure is detected the individuals concerned become patients. So health education has the potential to be iatrogenic by disempowering individuals and turning them into patients [40]. There is also a change in the relationship between the health care provider and the individual receiving care. The patient/nurse role introduces elements of intimacy. if not of a persona! nature certainly of a professional one and changing boundaries, roles and power relationships.

A significant proportion of health education practice is based on the principle of discovering these risk factors at an early stage and turning the possible into probabilities. This is especially true when the underlying principle is based on detecting “problems in the mechanical functions of the body” [21]. The use of social indicators such as class are used to help the professional structure the health education input rather than being used to prepare the patient for the world outside the encounter.

8. Clinical health promotion

All the foregoing show that both health education and patient education are based on a medical mode! of operating and rely for their successful operation on the receiver of care occupying the patient role and the health care provider being perceived as the expert. Patient education is also dominated by the professional knowledge of the doctor or nurse and their expertise in illness and disease. This is different to the expertise required to manage illness in the social world. In the social world compliance is not just a matter of medical knowledge but influenced by social and other non-medical factors.

Clinical health promotion is an attempt to break free of the constraints of the medical mode! and move to a focus on empowering individuals. Clinical health promotion according to Herbert, Visser and Green [7] “predisposes, enables and reinforces people to take greater control of the non-medical determinants of their own health” (p. 224). Hellstrom [2] talks about helping people to establish their own health. In order for this to occur illness and disease must be established in the context in which it occurs. This may equate to using patient education approaches based on active participation and independent decision making rather than authoritative guidance.

Issues of context within patient education are subjugated to the disease mode! and are used as part of the process of informing the expert of the limitations of the encounter. Many of the non-medical presenting issues are turned into medical components to be dealt with in the encounter. What needs to occur is the location of the encounter in this wider context of non-medical determinants rather than the other way round. So the focus becomes one of how we can help people cope with their disease and how it interacts with their lives rather than using aspects of their lives to control the illness.

For example Close [41] says that patient education is about giving people information so they can exercise choice. Clinical health promotion involves going beyond the encounter and the expert/patient roles to a concern with working with the patient. It implies a partnership mode! of mutual interdependence in helping people to focus outside the encounter and the disease to identifying non-medical factors that influence their health and also helping them identify pos-
sible actions to influence and control these factors. At the moment indicators such as the social class of patients are used to inform the encounter and guide the education input of the health care provider, these need to be expanded to inform the choice people have outside the encounter and inform the doctor or nurse take “due cognisance of the social structural roots of their patients’ ill health” ([12], p. 110).

9. Conclusions

Many of the assumptions used in other studies to distinguish between health education and patient education have been explored and proved to be lacking in analysis. The skills involved are not substantially different. The claims of health education to work with well individuals ignores the tendency to create and encourage adoption of the patient role within the health education encounter.

Both health education and patient education rely on the roles of patient and expert being adopted. Changes in service delivery make it important to distinguish between the various approaches in order that health promotion and health education are not simply replaced in the community and primary care setting by patient education under the label of health promotion or health education. It is also important that patient education be recognised for what it achieves and not relegated to being a lesser form or poor cousin to health education.

Patient education need not be defined in narrow terms of being just the imparting of information or the as being condition specific but can be viewed in the broader realm of the concept of care: concerned with relationships and partnership arrangements. It can also begin to focus on helping individuals identify circumstances which impact on their health (and disease process). This locates disease and illness within the broader confines of an individual’s life. This allows the contribution of patient education to health promotion to be clearly demonstrated and once this begins to occur then clinical health promotion is occurring.

Patient education can be a process not relying on one model of implementation. Clinical health promotion is an expansion of this process and not the introduction of a new way of education. It is to do with the attitudes and approach of the health care provider to the encounter. It demands a new approach to roles and relationships being adopted.

Patient education still has a role as part of an overall health promoting process but if we want to influence health then clinical health promotion is the way forward. The practice of clinical health promotion is an option for all staff not just those in community settings as claimed by Herbert, Visser and Green [7], although primary care staff may have some advantages over institutional based staff. Clinical health promotion to borrow from feminist ideology makes the individual encounter political by focusing beyond the encounter and the disease, to life itself.

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